

Scottish Parliament Region: North East Scotland

Case 200501162: A General Practitioner in the Grampian NHS Board area

Introduction

1. On 1 August 2005 the Ombudsman received a complaint from a woman (Mrs C) that her late husband (Mr C)'s general practitioner (GP) was responsible for his death because of his incorrect diagnosis and inadequate standard of care at several telephone and face-to-face consultations between December 2003 and February 2004.

2. The complaint from Mrs C which I have investigated was whether the care and treatment of her husband between December 2003 and February 2004 were reasonable.

3. Following the investigation of all aspects of this complaint I did not uphold it (see paragraphs 11 to 12) because, on a balance of probability, the evidence shows that Mr C was treated appropriately.

Investigation and findings of fact

4. I was assisted in the investigation by one of the Ombudsman's clinical advisers, a GP. His role was to explain, and give an opinion on, the clinical aspects of the events. We examined the papers provided by Mrs C and the GP's Practice. Grampian NHS Board (the Board) were approached, to check that they did not hold any additional papers. To identify any gaps and discrepancies in the evidence, the content of some of the papers was checked against information elsewhere on the file and also considered against my own and the adviser's knowledge of the issues concerned. I am, therefore, satisfied that the evidence has been tested as robustly as possible, bearing in mind the difficulty of establishing the facts in a complaint about what someone said. Finally, in line with the practice of this office, the standard by which the complaint was judged was whether the events were reasonable, in the circumstances, at the time in question.

5. Mrs C and the GP have provided comments on a draft of this report.

6. I turn now to the events in question. Mr C was aged 59 and attended the GP regularly because of high blood pressure. Mrs C said that in December 2003 he became breathless and pale, with no energy. On 18 December 2003 the GP saw him, despite the fact that Mr C had no appointment and the GP had a full morning of appointments. The GP's records for that consultation state that, from what Mr C told him, he had classic reflux symptoms (backward flow through the digestive system). He prescribed a medication for reflux disease. He stated that Mr C's blood pressure was slightly high but was acceptable and he indicated that the cause was likely to have been a heated conversation in the reception area when Mr C had been trying to get an immediate consultation. There is no record of the symptoms which Mrs C described in her complaint, that is, shortness of breath, pallor or lack of energy. The adviser considers that if these had been mentioned, they should have been recorded. However the fact that the GP saw Mr C that day was an example of particularly good practice.

7. In his response to the complaint which Mrs C made to the Board, the GP said that Mr C telephoned him on 30 December 2003 and, although the GP made no written record, he believed that he gave Mr C standard advice for what appeared to be a viral infection. The adviser has said that, as all consultations, including those by telephone, should be recorded, this failure to do so was poor practice.

8. Mrs C said that on 21 January 2004 her husband woke up with a high temperature and that day saw the GP. She complained that, when she saw the clinical records, she noticed that Mr C's breathlessness, pallor and feelings of coldness at that consultation had not been recorded. The adviser has said that if they were mentioned by Mr C, they should have been recorded. The records describe blood pressure and a discussion about alcohol. In his response to the complaint, the GP said that he recalled the consultation because he particularly remembered something he said to Mr C about alcohol; he said that at no time did Mr C complain of the symptoms described by Mrs C and that if he had, he (the GP) would have recorded them and acted accordingly. Mrs C said that (at some point) the GP advised Mr C to take walks. The adviser has said that to give such advice was good practice and that the records indicate that Mr C's blood pressure was being well monitored.

9. At the next consultation, 4 February 2004, the GP's records state that Mr C had stopped taking the drug amlodipine because of side effects. Mr C had started to take this drug in November 2003 for his high blood pressure. The GP's response to Mrs C's complaint described the side effects as breathlessness, fatigue, palpitations, headache, dizziness and many others. The GP's response also said that the drug could have been responsible for the symptoms but that he did not give Mr C an alternative because Mr C firmly did not want to start anything new just before his holiday abroad and because Mr C's blood pressure at the time was relatively good. The adviser has confirmed that from a medical viewpoint this was perfectly reasonable.

10. Mr and Mrs C then went on holiday abroad, where, tragically, Mr C became ill and died. A foreign hospital medical report provided to me by Mrs C states that Mr C had been having medical treatment in the holiday resort for several days but attended the hospital at noon on 6 March 2004 because he was getting worse. His symptoms were difficulty in breathing, high temperature, chest pain and the coughing up of mucus. He was revealed to have a serious chest infection, severe anaemia and lowered white cells. He developed severe shock because the infection overwhelmed his system and during that same evening (6 March) he had a heart attack and died. The adviser has said that, even in fit people, this is not an unknown sequel to infection, although it is possible that Mr C was less able to resist the infection because of anaemia and lowered white cells.

Conclusions

11. I note the lack of record about the telephone conversation on 30 December 2003 (see paragraph 7). This was poor practice. I make no recommendation for action here because it was a minor point when considered against the other records and against the more serious issue of clinical treatment. But I invite the GP to ensure that all conversations are recorded in future.

12. As explained at paragraph 4, I am satisfied that the evidence in this case has been tested as robustly as possible. That includes the adviser's advice, which was unambiguous and was clearly and logically based on the paper evidence. Therefore, I accept that advice. The adviser considers that Mr C was treated appropriately for his high blood pressure. Mrs C believed that Mr C must have told the GP about his symptoms of breathlessness, paleness and lack of energy. The

adviser considers that if these were mentioned, he would have expected the GP to have done appropriate blood tests, which could have revealed anaemia. It is not possible to prove whether or not Mr C did mention these symptoms. In the absence of robust evidence, the practice of this office is to try to reach a decision which is based on a balance of probability. On that basis, the adviser has said that he would be surprised if those symptoms had been raised by Mr C because no mention is made of them in the records. I accept that view. Therefore, as there is no evidence of inadequate care and treatment between December 2003 and February 2004, I do not uphold the complaint.

27 June 2006

Explanation of abbreviations used

Mrs C	The complainant
Mr C	The complainant's late husband
the GP	Mr C's general practitioner
the Board	Grampian NHS Board